



# MEDICAL FACSIMILE COVER SHEET

(For Transmission of Individually-Identifiable, Confidential Medical Record Information)

## NATIONAL INSTITUTES OF HEALTH

Institute:  
Building:  
10 Center Drive MSC-  
Bethesda, MD 20892-  
Telephone:

Room:

FAX Number:

TO: \_\_\_\_\_

FROM: \_\_\_\_\_  
Name and Signature of Person Sending FAX

Phone Number: \_\_\_\_\_

Phone Number: (301) \_\_\_\_\_

Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Name of Credentialed Staff Member Authorizing Release

Number of Pages:  
(Including Facsimile Cover Sheet): \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date Transmitted: \_\_\_\_\_

CC Medical Record #: \_\_\_\_\_

### REASON FOR RELEASE (Select One):

- ☐ Patient Signed Consent  
☐ Emergent Medical Care

- ☐ Published Routine Use  
(Select One of the Routine Uses Below)

### ROUTINE USES (Select One):

- ☐ Physician/Organization Identified by Patient in MIS to Receive Reports ☐ Other  
☐ Medical Consultants ☐ Travel Arrangements ☐ Social Work Department Arrangement

### INFORMATION RELEASED (Select All That Apply):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Dictated Reports  | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Consultations | <input type="checkbox"/> Flow Sheets      |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Tissue Reports | <input type="checkbox"/> Measurements  | <input type="checkbox"/> Nuclear Medicine |
| <input type="checkbox"/> Heart Diagnostic  | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Radiology     | <input type="checkbox"/> Lab Results      |
| <input type="checkbox"/> Other _____       |   |  |   |

Forward Completed Cover Sheet to: Medicolegal Section, Medical Record Department,  
Building 10, Room 1N216, Phone: (301) 496-3331

#### Confidentiality Statement:

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